

CIVIL COMMITMENT: RECOGNITION OF PATIENTS'
RIGHT TO TREATMENT

Donaldson v. O'Connor, 493 F.2d 507 (5th Cir. 1974)

Plaintiff was involuntarily civilly committed to the Florida State Mental Hospital in 1957.¹ Before his release in 1971, he brought an action under 42 U.S.C. § 1983,² alleging that five hospital and health officials deprived him of adequate psychiatric treatment.³ A jury awarded compensatory and punitive damages against two physicians,⁴ and they appealed. The United States Court of Appeals for the Fifth Circuit affirmed and *held*: A nondangerous involuntarily committed mental patient has a constitutional right to treatment.⁵

1. Kenneth Donaldson was committed by a county court judge of Pinellas County, Florida, pursuant to Act of Aug. 1, 1955, ch. 29909, § 2, [1955] Fla. Laws 827 (now FLA. STAT. ANN. § 394.467 (Supp. 1974)). He was diagnosed as suffering from "paranoid schizophrenia," which is

characterized primarily by the presence of persecutory or grandiose delusions, often associated with hallucinations. Excessive religiosity is sometimes seen. The patient's attitude is frequently hostile and aggressive, and his behavior tends to be consistent with his delusions.

AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS § 295.3 (2d ed. 1968).

2. 42 U.S.C. § 1983 (1970) provides:

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.

3. *Donaldson v. O'Connor*, 493 F.2d 507, 510 (5th Cir. 1974), *cert. granted*, 43 U.S.L.W. 3239 (U.S. Oct. 21, 1974) (No. 8). Donaldson had previously brought fifteen unsuccessful petitions for a writ of habeas corpus in the state and lower federal courts in Florida. Petitioner's Brief for Certiorari at 10, *O'Connor v. Donaldson*, 43 U.S.L.W. 3239 (U.S. Oct. 21, 1974) (No. 8). On four occasions, he had unsuccessfully petitioned the Supreme Court of the United States. *Donaldson v. O'Connor*, 400 U.S. 869 (1970) (writ of certiorari); *Donaldson v. O'Connor*, 390 U.S. 971 (1968) (writ of certiorari); *Donaldson v. Florida*, 371 U.S. 806 (1962) (habeas corpus); *In re Donaldson*, 364 U.S. 808 (1960) (leave to file petition for writ of habeas corpus).

4. The judgment was against two physicians who were hospital administrators and Donaldson's attending physicians from 1957 to 1971. Compensatory damages were levied in the amounts of \$17,000 and \$11,500, and punitive damages were assessed at \$5,000 per doctor.

5. *Donaldson v. O'Connor*, 493 F.2d 507, 527 (5th Cir. 1974), *cert. granted*, 43 U.S.L.W. 3239 (U.S. Oct. 21, 1974) (No. 8).

Though statutory language varies,⁶ most states rely on two basic justifications for permitting the involuntary commitment⁷ of the mentally ill.⁸ First, for the benefit and protection of society, the state may act under its police power to confine those found to be dangerous.⁹ Secondly, under the *parens patriae* doctrine, the state may choose to commit a person for his own benefit.¹⁰ Inherent in both rationales is the

6. *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1203-04 (1974) (footnotes omitted) [hereinafter cited as *Civil Commitment*]:

The primary differences among the present state standards for involuntary commitment are contained in the statutory language setting forth the requisite impact or consequences of the mental illness. Fifteen jurisdictions authorize commitment only if the individual is mentally ill and dangerous to himself or others or is unable to care for his physical needs. Fourteen other states provide for commitment if the mentally ill person is dangerous or is in need of care or treatment, with twelve of these requiring that the person in need lack the capacity to make a responsible treatment decision. Seven states require that commitment be necessary to protect the welfare of the individual or the welfare of others, and fifteen others allow compulsory hospitalization based on a mental illness which renders the individual in need of care and treatment or a fit subject for hospitalization.

For a listing of the statutory language in the various states see *id.* at 1203-04 nn.11-14.

7. See generally Birnbaum, *A Rationale for the Right*, 57 GEO. L.J. 752 (1969) [hereinafter cited as Birnbaum]; Goodman, *Right to Treatment: The Responsibility of the Courts*, 57 GEO. L.J. 680 (1969); Katz, *The Right to Treatment—An Enchanting Legal Fiction?*, 36 U. CHI. L. REV. 755 (1969); *Civil Commitment* 1207-40.

8. See Livermore, Malmquist & Meehl, *On Justifications for Civil Commitment*, 117 U. PA. L. REV. 75, 80 (1968):

Obviously, the definition of mental illness is left largely to the user and is dependent upon the norms of adjustment that he employs. Usually the use of the phrase "mental illness" effectively masks the actual norms being applied. And, because of the unavoidable ambiguous generalities in which the American Psychiatric Association describes its diagnostic categories, the diagnostician has the ability to shoehorn into the mentally diseased class almost any person he wishes, for whatever reason, to put there.

9. Institutionalization under the police power concept is viewed as a form of preventive detention of the mentally ill individual who is dangerous to society or to himself. The current trend seems to be toward restricting the class of mental illnesses considered dangerous and increasing the degree of probable harm needed to support a finding of dangerousness. *Civil Commitment* 1205; see *Jackson v. Indiana*, 406 U.S. 715 (1972); *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated on other grounds*, 414 U.S. 473 (1973). But see *Fhagen v. Miller*, 29 N.Y.2d 348, 278 N.E.2d 615, 328 N.Y.S. 2d 393, *cert. denied*, 409 U.S. 845 (1972).

Although dangerousness is usually the standard for police power commitments, studies reveal that mental illness is a poor indicator of future dangerous conduct. Comment, *Wyatt v. Stickney and the Right of Civilly Committed Mental Patients to Adequate Treatment*, 86 HARV. L. REV. 1282, 1289-90 n.43, 1295 (1973); see Birnbaum 767 (facts do not support laymen's picture of the mentally ill as universally homicidal or suicidal).

10. Largely because of the uneasiness with the dangerousness standard, see note 9 *supra*, the therapeutic intent of involuntary commitment under *parens patriae* has been

nonpunitive nature of the confinement, the purpose being to "treat,"¹¹ "cure,"¹² or "rehabilitate."¹³

Although recognition by the legal system of a right to treatment¹⁴ follows logically from the nonpenal motives underlying the commitment statutes¹⁵ and the deprivations of a committed individual's freedoms,¹⁶ the courts have refused to deal precisely with what is meant by "treatment."¹⁷ Nevertheless, the states' purported purpose, to treat, is con-

increasingly emphasized. Katz, *supra* note 7, at 759. *Parens patriae* is translated as "father of his country" and refers to the state's power of guardianship over persons with disabilities. To commit a person under the rationale of *parens patriae*, recent cases maintain that the individual must be shown to lack the capacity to make treatment decisions. See, e.g., *Winters v. Miller*, 446 F.2d 65 (2d Cir.), *cert. denied*, 404 U.S. 985 (1971); *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated on other grounds*, 414 U.S. 473 (1973).

11. *Stachulak v. Coughlin*, 364 F. Supp. 686, 687 (N.D. Ill. 1973).

12. *Wyatt v. Stickney*, 325 F. Supp. 781, 784 (M.D. Ala. 1971).

13. *In re Ballay*, 482 F.2d 648, 658-59 (D.C. Cir. 1973) (dictum).

14. Dr. Morton Birnbaum is usually credited as being the first to solicit the courts' recognition of the right to treatment. As he originally conceived it, the concept was to entail releasing all mental patients, dangerous or not, who were not receiving proper medical treatment. The hope was that, if such a course were taken, new and adequate treatment facilities would result from the public's awareness and concern. See Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960); Kittrie, *Can the Right to Treatment Remedy the Ills of the Judicial Process?*, 57 GEO. L.J. 848, 866 (1969). Kittrie contends that the right to treatment was alluded to in *Miller v. Overholser*, 206 F.2d 415 (D.C. Cir. 1953), and *Commonwealth v. Page*, 339 Mass. 313, 159 N.E.2d 82 (1959). See also Birnbaum, *supra* note 7. The right to treatment has not been limited to residents of mental institutions, but is also applicable to others involuntarily confined. See, e.g., *Nelson v. Heyne*, 491 F.2d 352 (7th Cir. 1974) (juvenile delinquents); *Welsch v. Likins*, 373 F. Supp. 487 (D. Minn. 1974) (mentally retarded).

15. "Hospitalization in this respect bears no relation to a jail sentence. A jail sentence is punitive . . . Hospitalization is remedial . . ." *Overholser v. Lynch*, 288 F.2d 388, 394 (D.C. Cir. 1961); see, e.g., *Jackson v. Indiana*, 406 U.S. 715, 738 (1972); *Rouse v. Cameron*, 373 F.2d 451, 452-53 (D.C. Cir. 1966); *Millard v. Cameron*, 373 F.2d 468, 473 (D.C. Cir. 1966); *Wyatt v. Stickney*, 325 F. Supp. 781, 784 (M.D. Ala. 1971); *Nason v. Superintendent of Bridgewater State Hosp.*, 353 Mass. 604, 611, 233 N.E.2d 908, 912-13 (1968); *Commonwealth v. Page*, 339 Mass. 313, 316-17, 159 N.E.2d 82, 85 (1959).

16. A committed person may not only be denied his liberty indefinitely, but may also lose his rights to have custody of his children, to vote, to serve on a jury, to obtain a driver's license, or to make a contract. *Civil Commitment*, *supra* note 6, at 1198-99. After release, moreover, he may be socially ostracized and stigmatized like a convicted criminal. *Id.* at 1200; see *In re Ballay*, 482 F.2d 648, 668-69 (D.C. Cir. 1973).

17. Statutes are seldom helpful in supplying a court with a useful definition. Many provide only that treatment should be accorded to the extent of available facilities and funds. Several states have patterned their commitment statutes on the *Draft Act Governing Hospitalization of the Mentally Ill*. See *Civil Commitment* 1319-21. Section 19 of the *Act* provides:

sidered by the courts to be not just a desirable goal, but rather a duty which must be fulfilled.¹⁸ Relying at times on statutory requirements,¹⁹ but more frequently on the constitutional guarantees of due process,²⁰ equal protection,²¹ and the prohibition against cruel and un-

Every patient shall be entitled to humane care and treatment and, to the extent that facilities, equipment, and personnel are available, to medical care and treatment in accordance with the highest standards accepted in medical practice.

THE MENTALLY DISABLED AND THE LAW 454, 461 (rev. ed. S. Brakel & R. Rock 1971), reprinting NATIONAL INSTITUTE OF MENTAL HEALTH, FEDERAL SECURITY AGENCY, A DRAFT ACT GOVERNING HOSPITALIZATION OF THE MENTALLY ILL (Public Health Service Pub. No. 51, 1952).

18. See cases cited note 15 *supra*.

19. See *Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966) (recognized right to treatment under 1964 Hospitalization of Mentally Ill Act for District of Columbia). But see *Birnbaum* 758 (contending that court in *Rouse* misconstrued statute and that right to treatment should have been based on constitutional grounds).

20. See *Wyatt v. Stickney*, 325 F. Supp. 781, 785 (M.D. Ala. 1971):

To deprive any citizen of his or her liberty upon the altruistic theory that confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process.

Accord, *Welsch v. Likins*, 373 F. Supp. 487 (D. Minn. 1974); *Stachulak v. Coughlin*, 364 F. Supp. 686 (N.D. Ill. 1973). See generally Kadish, *Methodology and Criteria in Due Process Adjudication—A Survey and Criticism*, 66 YALE L.J. 319 (1957); Comment, *supra* note 9; Note, *Civil Restraint, Mental Illness, and the Right to Treatment*, 77 YALE L.J. 87 (1967). Court decisions have also attacked procedural due process violations in the commitment process. See, e.g., *In re Ballay*, 482 F.2d 648 (D.C. Cir. 1973); *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972), vacated on other grounds, 414 U.S. 473 (1973). But see *Logan v. Arafeh*, 346 F. Supp. 1265 (D. Conn. 1972), *aff'd sub nom. Briggs v. Arafeh*, 411 U.S. 911 (1973); *Fhagen v. Miller*, 29 N.Y. 2d 348, 278 N.E.2d 615, 328 N.Y.S.2d 393, *cert. denied*, 409 U.S. 845 (1972).

21. Both old and new equal protection arguments have been made. See, e.g., *Rouse v. Cameron*, 373 F.2d 451, 459 (1966) (dictum) (compelling reason is needed to justify failure to provide adequate treatment); *Director of Patuxent Institution v. Daniels*, 243 Md. 16, 41, 221 A.2d 397, 411, *cert. denied*, 385 U.S. 940 (1966) (test to determine validity of defective-delinquent statute was whether it was reasonably calculated to achieve its legislative purpose). Commentators have also advocated that "strict scrutiny" should be the approach used in upholding the right to treatment. See *Chambers, Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives*, 70 MICH. L. REV. 1107, 1161-62 (1972); Comment, *supra* note 9, at 1293-94. For other equal protection arguments see *Jackson v. Indiana*, 406 U.S. 715 (1972); *Humphrey v. Cady*, 405 U.S. 504 (1972); *Baxstrom v. Herold*, 383 U.S. 107 (1966); *Sas v. Maryland*, 334 F.2d 506 (4th Cir. 1964); *Nason v. Superintendent of Bridgewater State Hosp.*, 353 Mass. 604, 233 N.E.2d 908 (1968). See generally Ely, *The Wages of Crying Wolf: A Comment on Roe v. Wade*, 82 YALE L.J. 920 (1973); Gunther, *The Supreme Court, 1971 Term—Foreword: In Search of Evolving Doctrine on a Changing Court: A Model for a Newer Equal Protection*, 86 HARV. L. REV. 1 (1972).

usual punishment,²² state and lower federal courts have upheld mental patients' right to receive treatment while confined²³ or, in the alternative, to be released.²⁴

Establishing the statutory and/or constitutional foundation from which the patient may assert his right to treatment is only the first step toward vindicating a right²⁵ that has virtually escaped judicial interpretation. The next step is to determine what treatment must be provided. In attempting to define treatment, however, most courts succeed only in modifying it with vague and nebulous adjectives, such as "adequate," "appropriate," "suitable," or "proper."²⁶ Thus, despite some general judicial pronouncements,²⁷ courts have failed to deal ex-

22. Most courts' reliance upon the eighth amendment stems from the decision in *Robinson v. California*, 370 U.S. 660 (1962) (making narcotics addiction a crime violates constitutional prohibition of cruel and unusual punishment since addiction is illness or condition, and not an act). These cases find the provision of treatment necessary to prevent an eighth amendment violation when confining persons with mental disabilities. See *Welsch v. Likins*, 373 F. Supp. 487 (D. Minn. 1974) (mentally retarded); *Martarella v. Kelley*, 349 F. Supp. 575 (S.D.N.Y. 1972) (juvenile delinquents); *United States v. Walker*, 335 F. Supp. 705 (N.D. Cal. 1971) (incompetent to stand trial); cf. *Trop v. Dulles*, 356 U.S. 86, 100 (1958); *Knecht v. Gillman*, 488 F.2d 1136, 1139 (8th Cir. 1973). See also *Jackson v. Indiana*, 406 U.S. 715, 735 (1972) (dictum); *Rouse v. Cameron*, 373 F.2d 451, 453 (D.C. Cir. 1966) (dictum).

23. See, e.g., *Stachulak v. Coughlin*, 364 F. Supp. 686 (N.D. Ill. 1973); *Wyatt v. Stickney*, 344 F. Supp. 373 (M.D. Ala. 1972); *Whitree v. State*, 56 Misc. 2d 693, 290 N.Y.S.2d 486 (Ct. Cl. 1968).

24. Some jurisdictions have also taken a least-restrictive-alternative approach. These courts maintain that individuals must not be institutionalized if other equally effective, but less restrictive, alternatives—such as outpatient community-based programs—might be employed. *Chambers*, *supra* note 21; see *Covington v. Harris*, 419 F.2d 617 (D.C. Cir. 1969); *Lake v. Cameron*, 364 F.2d 657 (D.C. Cir. 1966); *Kesselbrenner v. Anonymous*, 33 N.Y.2d 161, 305 N.E.2d 903, 350 N.Y.S.2d 889 (1973). But see *State v. Sanchez*, 80 N.M. 438, 457 P.2d 370 (1969), *appeal dismissed*, 396 U.S. 276 (1970).

25. *Civil Commitment*, *supra* note 6, at 1333 n.80.

26. "Adequate," as used in *Donaldson*, is the term most frequently used by courts in describing the standard of treatment that state institutions are required to provide. Many other adjectives, each as indefinite as "adequate," have also been used. See *Millard v. Cameron*, 373 F.2d 468, 472 (D.C. Cir. 1966) (suitable); *In re Jones*, 338 F. Supp. 428 (D.D.C. 1972) (proper); *Wyatt v. Stickney*, 334 F. Supp. 1341, 1343 (M.D. Ala. 1971) (effective); *Clatterbuck v. Harris*, 295 F. Supp. 84, 86 (D.D.C. 1968) (appropriate); *In re Maddox*, 351 Mich. 358, 362, 88 N.W.2d 470, 472 (1967) (curative). See also Schwitzgebel, *Right to Treatment for the Mentally Disabled: The Need for Realistic Standards and Objective Criteria*, 8 HARV. CIV. RIGHTS-CIV. LIB. L. REV. 513, 519 (1973).

27. *Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966), is illustrative of a decision in which the court's espousal of the need for adequate treatment was undermined by its use of ambiguous and vague language. Examples include "suitable treatment," "adequate in light of present knowledge," "need not show treatment will cure . . . but only that

licitly with the issue of evaluating the adequacy of treatment.²⁸

there is a bona fide effort to do so," "measures which will have therapeutic value." *Id.* at 456, 457. Given such nebulous guidelines, it is not surprising that, on remand, the hearings concluded that the patient was receiving adequate treatment, in spite of expert testimony that the therapy given the patient substantially deviated from professionally accepted standards. See Drake, *Enforcing the Right to Treatment*, 10 AM. CRIM. L. REV. 587, 592 (1972). See also Halpern, *A Practicing Lawyer Views the Right to Treatment*, 57 GEO. L.J. 782 (1969). The District of Columbia statute involved in *Rouse*, however, was similar to most other statutes in that its recognition of a right to treatment did not include any mention of adequacy.

Decisions in other contexts have also failed to describe in clear terms the treatment required. See, e.g., *Martarella v. Kelley*, 349 F. Supp. 575 (S.D.N.Y. 1972) (juvenile institutions); *Director of Patuxent Institution v. Daniels*, 243 Md. 16, 221 A.2d 397, cert. denied, 385 U.S. 940 (1966) (institution for defective delinquents); *People ex rel. Chumley v. Mancusi*, 26 App. Div. 2d 905, 274 N.Y.S.2d 477 (1966) (prisons). But see *Wyatt v. Stickney*, 344 F. Supp. 373 (M.D. Ala. 1972) (specific and detailed standards for mental hospitals were established on institution-wide basis).

28. A reason frequently given by courts for this failure is that setting guidelines in this field is beyond the scope of the judiciary's knowledge. Perhaps the courts should not be criticized too harshly for this attitude since they are confronted with "complex and occasionally conflicting theories of psychiatry and the myriad treatments available for mental illness . . ." *Civil Commitment* 1335 (footnotes omitted).

There are three main points of view regarding the courts' function in cases concerning mental illness and commitment. First, there is the attitude that regardless of the need for medical appraisals of treatment, whenever deprivation of liberty is involved it is the "law and not psychiatry [which] is the ultimate decision maker." Katz, *supra* note 7, at 765. Advocates of this position believe the administrative model is the solution. Under this approach, detailed findings and conclusions are not demanded of the judiciary; rather, its task is to determine whether qualified experts have studied the situation completely and can defend their decisions and judgments, and the consequences thereof. See Bazelon, *Implementing the Right to Treatment*, 36 U. CHI. L. REV. 742, 745 (1969):

No judge would claim the ability to prescribe a particular therapy for a "chronic undifferentiated schizophrenic." But neither would any judge allocate AM frequencies to avoid interference.

This position finds no practical difference between cases concerning mental illness and other medical malpractice suits. See Halpern, *supra* note 27, at 798; Schwitzgebel, *supra* note 26, at 516. Thus it is contended that psychiatrists' conduct should be measured against the standards of the school of medical opinion to which they subscribe. See W. PROSSER, *HANDBOOK OF THE LAW OF TORTS* § 32, at 163-64 (4th ed. 1971).

A second position held by some members of the legal community dictates a more self-restrictive role for the courts, on the ground that psychiatry is a less developed specialty and should be judged by less stringent standards than the rest of the medical profession. Proponents of this position advise courts to be cautious when entering the field and suggest that adequate treatment should be determined by independent administrative agencies comprising psychiatrists and legal experts. See Kittrie, *supra* note 14, at 881; Note, *supra* note 20, at 114. For criticisms of this position see Schwitzgebel, *supra* note 26, at 516.

The third view is best expressed by the American Psychiatric Association in its *Position Statement on the Question of Adequacy of Treatment*, 123 AM. J. PSYCHIAT. 1458, 1458, 1460 (1967):

In *Donaldson v. O'Connor*²⁹ the Fifth Circuit became the first court of appeals to acknowledge a constitutional right to treatment. In support of the derivation of this right from the due process clause,³⁰ the court offered a two-part theory: first, *parens patriae* patients must be given treatment in order to avoid a violation of the due process prohibition of arbitrary exercise of governmental power;³¹ and secondly, the state must extend a *quid pro quo* to justify confinement when an of-

The definition of treatment and the appraisal of its adequacy are matters for medical determination. Final authority with respect to interpreting the law on the subject rests with the courts. . . .

It is one thing, however, for outside community agencies to render constructive criticisms of the relative adequacy of a psychiatric facility and quite another for it [*sic*] to interpose its judgments on the professional managerial affairs of that facility.

Instead of offering the courts the assistance of the medical profession in framing proper standards, advocates of this view rebuke the courts for "trespassing on the domain of the psychiatrist." Halpern, *supra* note 27, at 802. This response of psychiatrists "has been a major factor in frustrating the more rapid development of concepts of adequate treatment." *Id.* at 803.

29. 493 F.2d 507 (5th Cir. 1974), *cert. granted*, 43 U.S.L.W. 3239 (U.S. Oct. 21, 1974) (No. 8).

30. *Id.* at 520. The court began "by noting the indisputable fact that civil commitment entails a 'massive curtailment of liberty' in the constitutional sense." *Id.* Though perhaps not totally incorrect, this supposition is at least an overstatement. As recognized in *New York State Ass'n for Retarded Children, Inc. v. Rockefeller*, 357 F. Supp. 752 (E.D.N.Y. 1973):

What constitutes due process under any given set of circumstances must depend upon the nature of the proceeding involved and the rights that may possibly be affected by that proceeding.

Id. at 762, citing *Cafeteria Workers Local 473 v. McElroy*, 367 U.S. 886, 895 (1961). Given the different facts and reasons underlying each individual's commitment, it is at least arguable that a "massive curtailment of liberty" does not occur when the purpose is solely rehabilitative as in *Donaldson*. See *Prochaska v. Brinegar*, 251 Iowa 834, 102 N.W.2d 870 (1960) (restraint for own welfare and protection is not loss of liberty within meaning of due process clause). In contrast, *Humphrey v. Cady*, 405 U.S. 504 (1972), from which the *Donaldson* court extracted the phrase "massive curtailment of liberty," *id.* at 509, had a very different fact situation. Petitioner there was convicted of contributing to the delinquency of a minor, with a maximum sentence of one year, but in lieu of imprisonment he was committed to a "sex deviate facility" in the state prison for a potentially indefinite time.

31. 493 F.2d at 520-21. Since the first part of the court's theory was directed only toward *parens patriae* patients, the three cases cited by the court are not very persuasive. Two—*Jackson v. Indiana*, 406 U.S. 715 (1972), and *Nason v. Superintendent of Bridge-water State Hosp.*, 353 Mass. 604, 233 N.E.2d 908 (1968)—involved plaintiffs who had been committed after being found incompetent to stand trial for a criminal offense. Such cases fall under the police power, as well as the *parens patriae* rationale. The other cited source, *Wyatt v. Stickney*, 344 F. Supp. 373 (M.D. Ala. 1972), was a class action, undoubtedly including parties not committed for reasons solely based on the *parens patriae* rationale.

fense against the state has not been proved in a proceeding subject to rigorous due process limitations.³²

Although throughout the opinion "treatment" is used synonymously with "adequate treatment,"³³ the *Donaldson* court decided that a formulation of standards for adequate treatment was not necessary to their finding. Rejecting, however, the defense of nonjusticiability,³⁴ the court cited *Wyatt v. Stickney*³⁵ as an example of a case in which a court set detailed structural requirements for a state mental institution.³⁶

32. 493 F.2d at 521-25. The second part of the court's theory drew no distinction between the *parens patriae* and police power rationales. The court cited numerous cases concerned with various types of "nonpenal commitment"—such as juvenile delinquency and mental retardation—and found a "near unanimous recognition" of the validity of the *quid pro quo* argument. *Id.* at 524. For criticism of this theory, see *Civil Commitment* 1325-26 n.39:

[The *quid pro quo* theory] implies that as long as procedural safeguards commensurate with a criminal-type proceeding are accorded, there is no right to treatment for police power patients. . . . Moreover, a state might turn the *quid pro quo* argument around and assert that, since treatment is in fact being provided, adequate procedural safeguards are not necessary.

33. 493 F.2d at 511: "Donaldson received no commonly accepted psychiatric treatment." *Id.* at 521: "[T]he due process clause requires that minimally adequate treatment be in fact provided."

34. In arguing the nonjusticiability of the issue raised in *Donaldson*, defendants relied principally on *Burnham v. Department of Pub. Health*, 349 F. Supp. 1335 (N.D. Ga. 1972). 493 F.2d at 525. The *Burnham* court had found that the claim of a right to treatment did not meet the test of justiciability set out in *Baker v. Carr*, 369 U.S. 186, 198 (1962):

[W]hether the duty asserted can be judicially identified and its breach judicially determined, and whether protection for the right asserted can be judicially molded.

The *Burnham* court had also quoted from *Greenwood v. United States*, 350 U.S. 366, 375 (1956):

The only certain thing that can be said about the present state of knowledge and therapy regarding mental disease is that science has not reached finality of judgment

35. 344 F. Supp. 373 (M.D. Ala. 1972).

36. The *Wyatt* court ordered compliance with proposed standards of adequate treatment in mental hospitals. The court's standards were detailed and comprehensive, setting minimum staff-patient ratios and requiring certain physical conveniences, such as minimum amount of floor space per patient. *See id.* at 379-86. The *Wyatt* court's method of evaluating treatment, called structural or institutional analysis, is the approach first advocated by Morton Birnbaum. *See note 14 supra*. Although it is perhaps the easiest technique to use, it has been severely criticized, especially by proponents of the individualized approach to creating standards. *See Schwitzgebel, supra note 26; Comment, supra note 9.*

In 1969 the American Psychiatric Association revised its position and no longer specified minimum staff-patient ratios. *See 126 AM. J. PSYCHIAT.* 879, 880-81 (1969). The chairman of the task force explained the reasons for the change:

We were aware that some find such ratios useful in convincing trustees and

This effort, however, to use *Wyatt* as evidence of the judiciary's ability to set standards was undermined by the *Donaldson* court's failure to use the structural analysis advocated in *Wyatt*.³⁷

The Fifth Circuit dismissed as inadequate the "milieu," "recreational," and "religious" therapies Donaldson had received, but the court accepted, as proper forms of treatment, alternatives that defendants had denied him—"occupational therapy," "grounds privileges," and "consultations with psychiatrists."³⁸ In reaching these conclusions, the court failed to recognize that medical studies have shown that the only effective means of treating Donaldson's diagnosed illness, schizophrenia, have been drugs and electroconvulsive therapy, and this treatment was refused by Donaldson.³⁹ Thus, it is difficult to justify the court's anal-

legislative committees of the need for larger budgets. Overriding this, however, was our view that patient-personnel ratios are meaningless as a general standard. The type and purpose of the facility, the objectives and methods of treatment, and the physical plant all influence the type and number of personnel required. Because of the infinite variety of facilities, the Task Force felt that no meaningful patient-personnel ratios could be stated.

Id. See also Schwitzgebel, *supra* note 26, at 528-29 (study showed no clear relationship between staff-patient ratio and success of released patients in community). Thus, the *Wyatt* court's institutional standards "would merely give rise to a rebuttable presumption that any given individual was receiving satisfactory treatment." Comment, *supra* note 9, at 1298.

37. The *Donaldson* court did not explore any aspect of the institutional standards prescribed in *Wyatt*, see note 36 *supra*, even though it had an opportunity to do so since the defendants relied upon insufficient resources as a defense. See note 42 *infra* and accompanying text.

38. 493 F.2d at 511, 513-14.

39. Donaldson was a Christian Scientist and, for that reason, refused to submit to the medication and electroshock forms of treatment. Although the involuntary commitment of an individual confers upon hospital authorities certain powers to treat the person against his will, there are limitations, one of which is religious belief. See *Winters v. Miller*, 446 F.2d 65 (2d Cir.), *cert. denied*, 404 U.S. 985 (1971). Thus, Donaldson's refusal to accept the somatic treatment may have been the primary factor accounting for his long stay without significant improvement. See Feinsilver & Gunderson, *Psychotherapy for Schizophrenics—Is it Indicated? A Review of the Relevant Literature*, 6 SCHIZOPHRENIA BULL. 11, 20 (1972): "Thus these studies offer persuasive evidence that drugs alone are the single most powerful and economical treatment for schizophrenic patients . . ."

It is somewhat unclear what the court meant when stating, "the simplest and most routine form of psychiatric treatment is to have a patient talk with a psychiatrist." 493 F.2d at 514. If psychoanalysis was being advocated, the court ignored the reality of the medical situation. Psychoanalysis is in disrepute in the treatment of psychotic disorders in most mental institutions in the United States. See Feinsilver & Gunderson, *supra*; Greenblatt, Grosser & Wechsler, *Differential Response of Hospitalized Depressed Patients to Somatic Therapy*, 120 AM. J. PSYCHIAT. 935 (1963); Huston & Lochner, *Involuntary Psychosis: Course When Untreated and When Treated with Electric Shock*,

ysis of the alternative therapies, since none of them was likely to have as much success as the somatic treatment to which the patient would not submit.

The court's acceptance of the jury's conclusion that defendants "wantonly, maliciously, or oppressively blocked" an earlier release for Donaldson⁴⁰ amounted to recognition of the jury's freedom to accept Donaldson's expert witnesses' opinions and to reject the conflicting views of defendants, who also qualified as expert witnesses.⁴¹ Finally, the court discounted the defendants' attempt to shift responsibility to the state on account of the hospital's limited resources.⁴²

59 ARCHIVES NEUROLOGY & PSYCHIAT. 385 (1948). For definitions and explanations of the various types of therapy generally administered to mental patients, see Note, *Conditioning and Other Technologies Used to "Treat?" "Rehabilitate?" "Demolish?" Prisoners and Mental Patients*, 45 S. CAL. L. REV. 616 (1972). For further discussion of the milieu therapy see notes 47-48 *infra* and accompanying text.

40. 493 F.2d at 515.

41. Since the psychiatrists testifying for plaintiff did not know him while he was institutionalized, much of the expert testimony was couched in terms such as "not 'consistent' with a treatment plan for a patient with Donaldson's history," and "'standard psychiatric practice' . . . [for] a patient of Donaldson's background, condition, and history." *Id.* at 513. Furthermore, the court admitted that the opinions of all three of Donaldson's expert witnesses were based "upon the hospital records, Donaldson's psychological reports, Donaldson's past history, and raw data from his psychological examinations." *Id.* at 517. It seems ironic that reliance was placed on this testimony, while the court criticized the defendants for failing to keep detailed and complete records. *Id.* at 515.

42. *Id.* at 518; *accord*, Wyatt v. Stickney, 344 F. Supp. 373, 377 (M.D. Ala. 1972) ("[T]he court is constrained to emphasize . . . that a failure by defendants to comply with this decree cannot be justified by a lack of operating funds"); *cf.* Millard v. Cameron, 373 F.2d 468, 472-73 (D.C. Cir. 1966) (failure to treat committed sexual psychopath not justified by lack of staff or facilities); Sas v. Maryland, 334 F.2d 506, 516-17 (4th Cir. 1964) (same concerning Maryland's defective-delinquent statute). See also Bazelon, *supra* note 28, at 749:

Courts cannot force legislatures to provide adequate resources for treatment. But neither should they play handmaiden to the social hypocrisy which rationalizes confinement by a false promise of treatment. Quite the contrary, courts should and must reveal to society the reality that often festers behind the euphemism of "hospitalization."

A lack of available funds, facilities, and the manpower needed to run the hospitals has placed the courts in a dilemma in the enforcement of their decisions. Promulgating the right to treatment is not enough if funds are not appropriated by the legislatures to allow its proper implementation.

This impasse raises still another enforcement issue that legal commentators are debating: What is the best method for the individual mental patient to pursue in order to obtain relief? The alternatives are (1) a suit for monetary damages under 42 U.S.C. § 1983, as in *Donaldson*, see note 2 *supra*; (2) habeas corpus relief, see, e.g., Covington v. Harris, 419 F.2d 617 (D.C. Cir. 1969); Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966); (3) monetary damages for false imprisonment; (4) mandamus to require

The most serious weakness in the court's decision was its insufficient rebuttal of the defendants' contention that the claim was nonjusticiable.⁴³ The first time in the opinion that a line was drawn between treatment per se and adequate treatment was the court's declaration: "There will be cases—and the case at bar is one—where it will be possible to make determination whether a given individual has been denied his right to treatment without formulating in the abstract what constitutes 'adequate' treatment."⁴⁴ Although extreme cases of neglect may arise, in which a court's result will require no express formulation of standards for adequacy of treatment, *Donaldson* was not such a case. The evidence before the court focused on a dispute between psychiatrists' judgments as to the therapy that should have been administered, and on the patient's refusal to submit to the only therapy likely to be successful. Such a situation cannot be easily dismissed as a clear case of general neglect of treatment.⁴⁵ By the very nature of its factual cir-

treatment; or (5) tort damages. There are a number of drawbacks to the first three strategies. Mental patients may be more likely than others to be unaware of their rights and have little access to legal assistance. Suits may be long, and there is always the possibility of harsh treatment of litigious patients by the staff. Comment, *supra* note 9, at 1304-05.

Problems also confront the patient seeking injunctive relief. Formulating as specific a decree as would be needed may require considerable expertise on the part of the court. Also, the court's inability to enforce the injunction if the legislature decides that other priorities are more deserving of limited funds may deter the court from issuing the injunction. See *Civil Commitment* 1338 n.96; Comment, *supra* note 9, at 1305.

There are two sharply conflicting views on the efficacy of individual tort actions. Schwitzgebel, *supra* note 26, at 530, asserts:

[C]ourts can fashion decrees in monetary terms and thereby eliminate the need for direct judicial intervention in the management of treatment institutions while still having a coercive, budgetary effect.

See *Whitree v. State*, 56 Misc. 2d 693, 290 N.Y.S.2d 486 (Ct. Cl. 1968) (court relied on elements of negligence and malpractice to give \$300,000 judgment). In opposition to tort actions, Morton Birnbaum argues that litigation may extend over a period of many years and may result in an antitherapeutic relationship between the staff and patient. He also notes the lack of success of medical malpractice suits in achieving improved care and believes that severely mentally ill persons often do not make satisfactory clients. Birnbaum, *supra* note 7, at 756-57 n.20.

43. See notes 33-35 *supra* and accompanying text.

44. 493 F.2d at 526. The court continued: "Neither judgment required any *a priori* determination of what constitutes or would have constituted adequate treatment, and of course no such determination was made." *Id.*

45. See Note, *supra* note 20, at 109-10 (emphasis added; footnote omitted):

[B]ut what if the doctors testify at length that a patient is receiving recreational therapy and is living in a therapeutic milieu which is reforming his shattered ego? Judge Bazelon seems to feel that standards or categories can be developed to label milieu therapy adequate for certain types of disorders and

cumstances, the *Donaldson* case demanded a judicial criterion for evaluating adequacy of treatment.

In spite of its statements to the contrary, the *Donaldson* court was implicitly using *some* basis to distinguish adequate from inadequate treatment.⁴⁶ In fact, by attempting to make value judgments regarding the various forms of treatment, the Fifth Circuit may have assumed a larger role than it is qualified to perform. Illustrative is the court's characterization of milieu therapy as

nothing more than keeping Donaldson in a sheltered hospital 'milieu' with other mental patients

. . . .

. . . In short, he received only the kind of subsistence level custodial care he would have received in a prison⁴⁷

Though there may be some controversy over the efficacy of the milieu form of treatment, it is nevertheless recognized by many psychiatrists as beneficial to some patients.⁴⁸ Thus, the court's analysis reflects what

not for others, but difficulties are apparent. There will be a significant divergence of expert opinion on the questions of appropriateness and effectiveness, and undoubtedly much reluctance on the part of psychiatrists to confine and narrow the applicability of the various modes of treatment. *There are no easy standards, except in the grossest cases of neglect.*

46. Although unarticulated, the basis of the court's standard of adequacy of treatment seems to be the "effectiveness" of the treatment. 493 F.2d at 514: "Once again, there was evidence to show that the situation improved when Donaldson was transferred to Dr. Hanenson's care." *Id.* at 526: "[T]he jury properly could have concluded that Donaldson had been denied his rights simply by comparing the treatment he received while he was under Gumanis's and O'Connor's care with that he received while under Hanenson's care" The court's implication, simply stated, is that since Donaldson was sufficiently cured to be released within a short time after Dr. Hanenson became his doctor, and since the treatment he had received for the previous ten years from defendants had not cured him, the latter's care must have been inadequate. The primary difficulty with assessing adequacy in terms of results is that improvement of a patient is not always a reliable index of whether he is being treated. *See Note, supra* note 20, at 107. It has been demonstrated, in fact, that for some disorders there is a spontaneous remission rate as high as twenty percent without any treatment, whereas other patients may not recover regardless of the treatment attempted. *See id.* at 107 n.81. Another defect in using effectiveness to measure treatment is that "dischargeability" and "treatability" are apt to be confused. *See Birnbaum, supra* note 14. *See also Postel, Civil Commitment: A Functional Analysis*, 38 BROOKLYN L. REV. 1, 42 (1971); *Comment, supra* note 9, at 1287-88.

47. 493 F.2d at 511-12.

48. American Psychiatric Association, *supra* note 28, at 1460:

All parts of the environment surrounding a patient have impact on him. The total effect of his overall milieu cannot be explained by analyzing each part of it separately. In one hospital ward setting all decisions must be made for him—when he will shave and shower, when and what he will look at on television, etc. In another ward situation general permissiveness may characterize

is actually at stake between the differing attitudes toward the judiciary's role "in inducing change . . . when legislatures and executives have failed to act."⁴⁹

Despite the shortcomings in the *Donaldson* court's reasoning, the result reached is likely to be viewed favorably as a progressive step toward achieving better care for the mentally ill.⁵⁰ Nevertheless, the court's refusal to make an express determination of what constitutes adequate treatment, in conjunction with a misplaced reliance on *Wyatt*, may set an unsatisfactory precedent.⁵¹ Merely to award damages for "inadequate" treatment of an involuntarily civilly committed mental patient is not enough; the establishment of practical standards, easily employed in the determination of adequacy, is essential if relief is to be provided to all deserving patients without unduly restricting the institutions' and physicians' efforts to treat the mentally ill.⁵²

the milieu. Either situation may have a therapeutic or antitherapeutic effect on the disease process.

Note, *supra* note 39, at 621 (milieu therapy is "the scientific manipulation of the environment aimed at producing changes in the personality of the patient"). See also American Psychiatric Association, *supra* note 28, at 1459:

[I]t is unsound to dismiss a procedure as "purely custodial" or "purely punishing" without assessing the total circumstances on which it has been prescribed. The procedure is often of therapeutic value. A program that has therapeutic value for one patient may be of no benefit to another. Some patients, for example, manifest acute anxiety when placed in open wards; others panic when placed behind locked doors.

49. *Kittrie*, *supra* note 14, at 876; see note 28 *supra*.

50. Cf. note 14 *supra*.

51. For instance, a court in a subsequent case may follow *Donaldson's* directions, apply the *Wyatt* institutional analysis, and find (as did the *Donaldson* court) no need to go further than a simple declaration that the treatment is or is not adequate. An anomalous result may occur if a hospital meets the structural standards for adequate treatment set out in *Wyatt*, but a patient is not receiving treatment adequate to his needs.

52. As indicated in note 46 *supra*, "effectiveness" or "improvement" alone should not be the standard for determining adequacy of treatment. Nevertheless, the absence of improvement may be the starting point for creating a test for adequate treatment. One possible test would be the following: If the records of a patient show no improvement (improvement would have to be measurable, probably in respect to current medical knowledge, with the key being the time of release), if there is no sufficient explanation for the lack of improvement, and if alternative methods of treatment have not been tried, then the treatment should be considered inadequate. In contrast, even though improvement appears to be lacking or is minimal, if the records indicate alternative treatments have been legitimately utilized and different physicians have been in attendance periodically, then the treatment received should be deemed adequate. In addition, it may be feasible to require a more rapid turnover of a patient's attending physicians if the patient does not respond favorably to the treatment provided. Such a procedure would not only give the patient a broader exposure to the varying opinions of different psychiatrists and the different schools of thought prevalent in psychiatry, but would also eliminate the likelihood of psychiatrists' being found to have "wantonly and maliciously"

denied patients adequate treatment merely because the patients have been under their care for a long time without improvement.

If the court implemented such a test, mental hospitals might be motivated to initiate better periodic-review programs to discover the validity of a patient's continued confinement. And, as a consequence, fewer determinations of adequacy of treatment might be required of the legal system. For a discussion of current review procedures, see *Civil Commitment* 1378.